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Case report

Determining competency in the sexually assaulted patient: A decision algorithm

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ABSTRACT

The determination of competency for decisions regarding one's care is of great individual importance as it represents a basic human right. Often, in Emergency Nursing, we are presented with situations that require difficult decisions that must be made in a brief time frame. The role of the Sexual Assault Nurse Examiner (SANE) in providing assessment and care to victims of assault is crucial to initiating the restoration of health and dignity of the patient in a tragic set of circumstances. Patients who present for SANE examination may have issues surrounding their capacity to make competent decisions regarding their assessment and care, further complicating an already tenuous situation. SANE nurses should be knowledgeable concerning competency and care issues and utilize a methodical process to guide their decision-making.

1. Introduction

Sexual assault examiners are required to obtain informed consent from their patients prior to initiating a physical and forensic examination. Because informed consent can only be given by a competent individual, health care providers often experience much apprehension over their responsibility to determine competence/capacity in the patients they care for. Although the determination of incompetence takes a legal proceeding and establishment of mental capacity is based on clinical assessment findings, the terminology will be used interchangeably in this article because of the inconsistent distinctions found in both legal and medical literature.

A significant factor that affects the competency decision-making process is the fact that a divergence exists between the standards for determination of competency between medical and forensic examinations. Following are brief descriptions of the three accepted standards used when making decisions about mental capacity with regards to a patient's ability to concur with or refuse a treatment or examination.[1–4]

Standard 1, the least stringent of these, applies to decisions that are not dangerous and are obviously in the patient's best interest. This applies to an acute, critical illness/injury which is life threatening. Agreeing to an effective available treatment with minimal risks is viewed as a competent decision, even though the person may have some cognitive impairment secondary to the seriousness of the illness/injury, as long as the person can demonstrate an awareness of the general situation. Concurrence with what is deemed the rational choice in this medicinal situation satisfies the decisional component of informed consent. This allows for those with senility, mild retardation, and intoxication to be considered competent. This standard does not apply to forensic examination because in the instance of a sexual assault victim being critically ill or injured, the medical examination and subsequent treatment take precedence over the collection of forensic evidence.

Standard 2 deals with situations where the treatment/examination is of less definite benefit. The patient must be able to demonstrate an understanding of the risks and consequences of the different options and then be able to make a decision based on their assimilation of the information. This standard does not require the person to articulate the specific concepts of the treatment options; a general comprehension, as interpreted by the health care provider, is sufficient. Severe mood disorders, moderate to severe retardation, exacerbation of other psychiatric disorders, severe shock (emotional or physical), delusions, dementia, or intoxication will render a person incompetent to make this type of decision. Forensic examination/treatment and evidence collection fall under this standard as do many medical treatments.

Standard 3 requires that the highest level of mental capacities be demonstrated for an individual to be considered competent. This applies to medical decisions when diagnostic results are certain, effective treatment is available, and death is expected if treatment is declined. Since a decision to reject treatment seems to go against fundamental rationality, a person must be able to satisfy the most

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complex standard of competency for their decision to be respected. Competency in this instance requires the aptitude to realize the magnitude and consequences of the choice being made. A person must exhibit the ability to verbalize and rationalize arguments while maintaining consistency in discussions with the health care provider. The high level of mental ability required for competency to formulate a decision of this type is impaired by less severe psychiatric abnormalities. Much lower levels of mental conditions are sufficient to generate an assumption of incompetency. This elevated standard does not apply to forensic examination because as with Standard 1, forensic treatment does not deal with life and death situations and defers priority to medical treatment.

Yet another confounding issue for sexual assault examiners is whether an examination is considered therapeutic. If the sexual assault program operates for the sole purpose of collecting forensic evidence for possible legal proceedings then the exam is not therapeutic and the ethical decisions are based upon what is mandated by the legal system with only a secondary concern for the patient. In contrast, if the program is designed to include not only the collection of forensic evidence but also treatment of possible sexually transmitted diseases, pregnancy, HIV, and arranging for psychological counseling, then it is considered therapeutic and the ethical basis is the same as when dealing with medical patients: doing what is in the best interest of the patient. This distinction between whether a program is therapeutic or non-therapeutic would also affect whether a third party could consent for the exam, as well as the information that would need to be covered during the informed consent process.

2. Case presentation

A 24 year old female with a history of psychosis presented to the Emergency Department, with a representative of the group home in which she lived reporting she had been sexually assaulted. The sexual assault nurse examiner (SANE) performed a primary assessment as advocated by the Trauma Nurse Core Course. After careful assessment, the SANE determined that this patient had no life threatening issues such as airway obstruction, breathing difficulties, or circulatory compromise, requiring emergent medical attention. The young woman was alert and oriented to person, place, and event, although she was very anxious, tearful, experiencing auditory hallucinations, and demonstrating some behaviors indicative of paranoia. At this time the SANE performed a brief secondary assessment to address the possibility of any underlying traumatic or medical causes for the behavior other than the sexual assault itself. Causes such as pre-existing medical conditions, concussive affects, and internal injuries that might have exacerbated or altered the expected psychological response to the sexual assault were considered. She found the victim to have normal vital signs and to be without extenuating findings to explain the current psychological state. The SANE also observed the overall disheveled appearance, and more specifically, the torn clothing in which the patient had presented. The victim was refusing the history collection, physical exam, forensic evidence collection, and therapeutic treatment components of the sexual assault exam. Secondary to the psychiatric signs being exhibited by the woman and her inability to assimilate and give a general summation of the information that had been provided to her, the SANE concluded this young woman was unable to comprehend the medical/legal risks and benefits of the forensic exam.

Based on the SANE's clinical experience and training in forensic evidence collection, she concluded that the patient's psychiatric needs must now become the primary focus to ensure mental capacity prior to a definitive decision being made regarding the forensic examination and treatment. After therapeutic communication and other calming measures failed, the patient was offered the options of receiving some medication to help calm her and the opportunity to speak with someone from the psychiatric emergency area. After the woman agreed to these treatments, the SANE told her she would like to speak to her again before she left the hospital. The patient was agreeable and the representative from the group home committed to returning the patient to the Emergency Department subsequent to completion of evaluation and treatment by psychiatry. The SANE escorted the patient and her representative to a psychiatric emergency treatment room.

Upon completion of the psychiatric evaluation and treatment, the woman returned to the sexual assault examination room. The woman was much calmer and no longer showing outward signs of paranoia or other psychotic behaviors. The SANE again explained what the examination and forensic evidence collection would entail and the importance of the evidence in legal proceedings, as well as the ramifications if the examination was refused. At this time, the patient was able to verbalize in her own words her understanding of the information she had received. She declined to have the sexual assault examination, stating that she felt it was better for her at this point in time not to pursue the situation further. She voiced concern over the possibility of being evicted from the group home because of being a perceived trouble-maker if she engaged in any legal proceedings. She reported not having any other viable options at this time since she was fairly new to the area and did not have any local relatives. Upon hearing this explanation, the SANE offered this young woman the option of anonymous collection; this being where a complete forensic examination and subsequent treatment are undertaken but the evidence is not submitted immediately to the appropriate law enforcement agency, instead it is stored in a secure/locked area within the examining institution for a pre-determined amount of time to allow for a delayed entry into the legal system if the victim decides to prosecute at a later time. This option was declined as well. Although the SANE did not agree with the final decision, she did feel that the young woman demonstrated the capacity to make an informed choice. Based on this case and the significant prevalence of sexual abuse among vulnerable populations,[5–7] a policy and procedure was developed and a decision-making algorithm (Appendix A) was instituted for determination of competency within the context of sexual assault assessment and examination.

3. Review of the literature

The SANE is responsible for the sexual assault victim's medical, psychological, and forensic needs. The SANE achieves this by providing crisis intervention and emotional support, preserving the patient's dignity, and initiating the healing process by allowing the person to make decisions about their examination. This process enables victims of sexual assault to take the first step toward regaining control and overcoming feelings of vulnerability.[8–11] S/he acts as a patient advocate and in doing so must assess the patient's ability to adequately comprehend the options concerning the care that is to be provided and the issues surrounding the care process. Regardless of the geographical location of practice, there are fundamental considerations that must be evaluated in order to preserve the patient's and provider's rights with respect to the patient care decision-making process. These fundamental factors can be defined as: competency, capacity, and sustained hemodynamic stability. A safe patient-centered final decision will be reached, regardless of the context, when these factors are evaluated using a decision-making process grounded in an ethical framework.

The following matrix (Fig. 1) describes the four (4) possible choices concerning the decision to receive and perform a SANE examination.

	SANE exam outcomes matrix	
	SANE's Decision	
	Yes exam	No exam
Patient's Decision: Yes Exam	**OPTION A** Exam performed	**OPTION B** Exam performed, reasons for concern documented via the Performance Improvement process
Patient's Decision: No Exam	**OPTION C** See competency/capacity decision-making algorithm. If both are determined to be present, document in the medical record. Provide discharge instructions to encourage future SANE evaluation if patient changes mind. AMA form should be completed.	**OPTION D** Reason for why patient and provider do not want to proceed with exam documented in the medical record. AMA form should be considered.

Fig. 1. Decision option matrix.

As outlined in the matrix, the complication that is most tenuous is the one in which the patient decides not to receive the exam (Option C), yet the provider feels that it is necessary given the situation. This scenario usually occurs when a decision of competency on the part of the patient is at question. In order to develop the decision-making algorithm that is based from an ethical perspective, a review of federal, state, and local laws concerning competency and more specifically, competency in making healthcare decisions, was warranted. Competence is not a comprehensive concept, with the essential elements of competency remaining a matter of dispute.[12,13] Since most diagnoses are accompanied by a spectrum of severity, no diagnosis in which consciousness is maintained is invariably predictive of incompetence. This holds true for diagnoses related to physical as well as mental health. According to the American Bar Association, competence/capacity exists along a continuum.[14] Within the state of Texas, competency is defined as possessing the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision.[15] Local county and city laws were reviewed and concur with state law. Finally, institutional policy should be considered. The decision to amend or add policy concerning competency should be reviewed in a systematic manner using a multidisciplinary approach with involvement by representatives from the Emergency Department, the SANE program, senior administration, and the legal/risk department as well. Additionally, language addressing the determination of whether or not a SANE program meets therapeutic guidelines should also be added in policies.

4. Discussion

Unfortunately, many situations in the Emergency Department are fraught with tough decisions that broach the bounds of ethical and moral judgment. Sexual Assault Examination by its very context has the potential to cross into these dilemmas. Because the determination of competency to give informed consent for medical or forensic examination is fundamentally dependent on regional, jurisdictional, and institutional requirements, sexual assault examiners should be extremely familiar with existing laws and hospital policies concerning competency. S/he must also be familiar with the scope of advanced directives, health care proxies, and legal guardianships as well as their limitiations; realizing that these are an extension of the patient, not a replacement for the patient's involvement in their own healthcare. The SANE should act as a resource for the development of policy whenever necessary to help providers deal with the difficult issues concerning competency. Secondly, SANEs should participate in local and regional groups that address ethical and moral issues related to patient care, in order to advocate further for the unique needs of the victims of sexual assault. Finally, sexual assault examiners should provide continuous education within their own institutions as well as locally, regionally, and nationally to ensure healthcare providers and lawmakers are knowledgeable in the statistics and opportunities to better care for these unique patients. In this manner, SANEs can provide another avenue of service to their patients and the providers with whom they work.

5. Conclusion

Often victims of sexual assault have their mental capacity assessed and sometimes questioned when presenting to the hospital for treatment. Sexual assault examiners must make a clinical judgment as to whether the victims they encounter possess the intellectual aptitude to participate in the informed consent process. The examiners must balance the need to deliver appropriate patient care with the victim's right to autonomy. A victim's mental capacity may be impacted by fear, pain, anxiety, or an exacerbation of a pre-existing condition. Steps need to be taken to alleviate as many of these influences as possible before making a determination of the individual's capacity to give informed consent. When a dilemma arises, experienced sexual assault examiners rely on accepted institutional policy/procedure, advanced education, and ethical guidelines to ensure the most appropriate treatment decision is reached for victims of sexual assault.

Conflict of interest

None.

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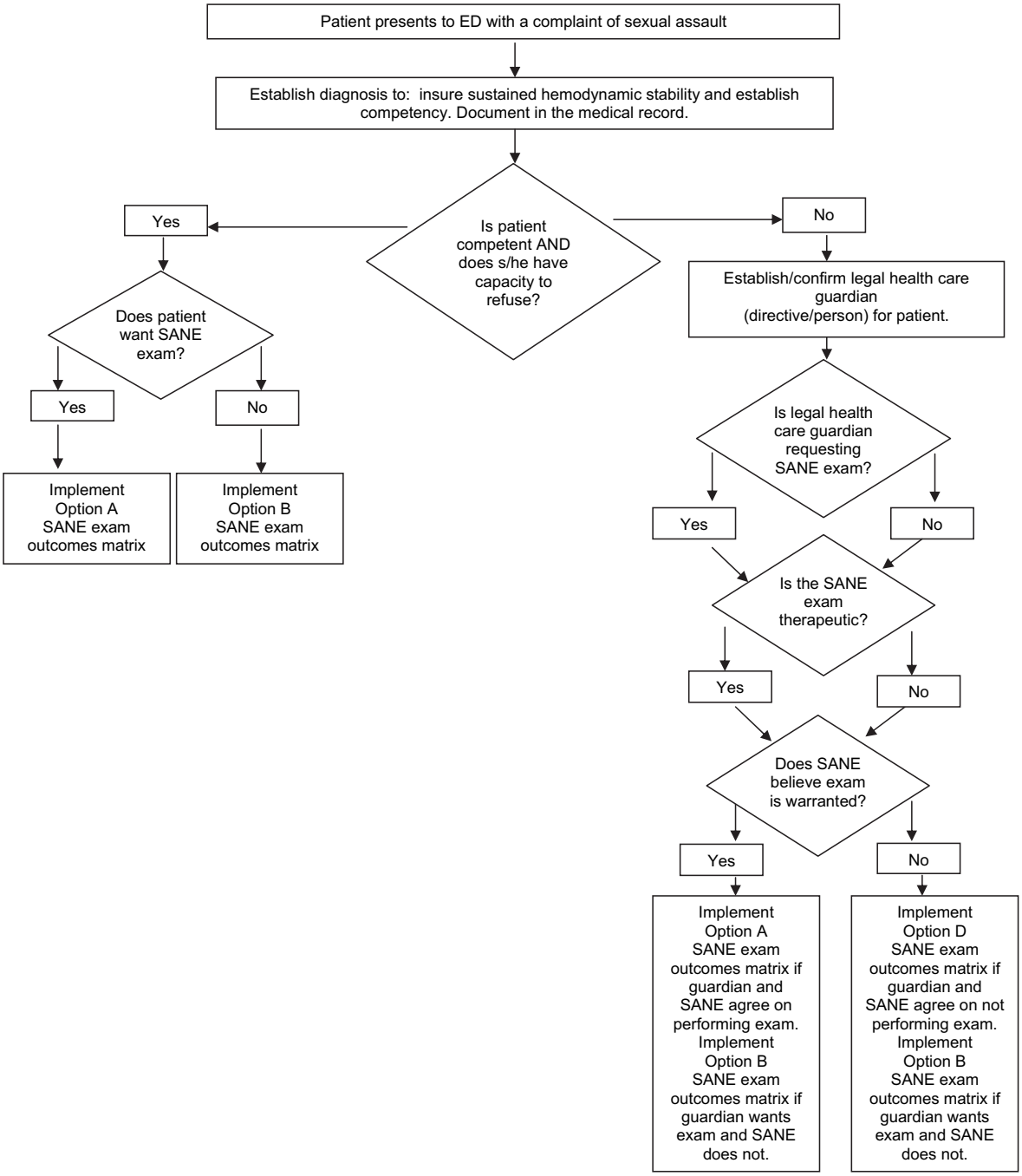
Ethical approval

This case study was given Ethical Approval by the JPS Health Network internal review board.

Appendix A. Sexual assault decision-making algorithm. Standard 2: establishing competency/capacity



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